Arkansas Department of Health is an approved provider of continuing nursing education by the Arkansas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The planning committee & faculty attest that NO relevant financial, professional or personal conflict of interest exists, nor was sponsorship of commercial support obtained, in the preparation or presentation of this educational activity.

All Continuing Nursing Education credits related to this module will expire on 3/31/2016.

Cervical Cancer Module III

Results, Staging and Follow-Up

- The clinician will be able to discuss the different types of test results
- Review and apply the algorithms based on various test results
- Determine the most appropriate plan of action for follow-up
- Identify clients who are at risk for noncompliance with treatment regimen
- Recognize when to refer a client for Case Management
- Follow the correct procedure for Case Management referrals

Test Results

Atypia

Undefined abnormality

Atypical Squamous Cells (ASC)

This diagnosis is given if the degree of atypia is not enough to diagnose squamous intraepithelial lesion

Atypical Squamous Cells of Undetermined Significance (ASC-US)

Unable to determine the precise significance of the atypical cells

Atypical Squamous Cells with possible High Grade Squamous Intraepithelial Lesion (ASC-H)

Atypical squamous cells present but can't exclude High Grade Squamous Intraepithelial Lesion (HSIL) yet it lacks the criteria needed for a definitive interpretation

Abnormal

Abnormal changes in either the squamous or glandular cells

Squamous Intraepithelial Lesion (SIL)

Immature dysplastic cells are present, there is an increased size in the nucleus and the amount of chromatin is increased but a decrease in cytoplasmic area is noted.

Low grade SIL

Cervical Intraepithelial Lesion (CIN 1) mild dysplasia and (HPV) infection present

High grade SIL

This contains both CIN II and CIN III which is classified as moderate to severe dysplasia and/or carcinoma in situ[1].

[1] http://adhfilehold/fh/filehold/webclientportal/libraryform.aspx

Staging

The staging system is a way to determine how far the cancer has spread. The size of the tumor, the tumor depth in the cervix and the spread to lymph nodes or distant organs provides a method to classify the cancer stage.

Once cancer is diagnosed and staged, the stage does not change even if the cancer metastasizes to other areas. A cancer that comes back or spreads is still referred to by the stage it was given when it was first found and diagnosed. New information is added to the diagnosis to explain the current disease status[2].

Tumor Extent (T)

Tis: The cancer cells are only found on the surface of the cervix (in the layer of cells lining the cervix), without growing into deeper tissues.

T1: The cancer cells have grown from the surface layer of the cervix into deeper tissues of the cervix. The cancer may also be growing into the body of the uterus, but it has not grown outside the uterus.

T1a: There is a very small amount of cancer, and it can be seen only under a microscope.

- **T1a1**: The area of cancer is less than 3 mm (about 1/8-inch) deep and less than 7 mm (about 1/4-inch) wide.
- **T1a2**: The area of cancer invasion is between 3 mm and 5 mm (about 1/5-inch) deep and less than 7 mm (about 1/4-inch) wide.

T1b: This stage includes stage I cancers that can be seen without a microscope. This stage also includes cancers that can only be seen with a microscope if they have spread deeper than 5 mm (about 1/5 inch) into connective tissue of the cervix or are wider than 7 mm.

- **T1b1**: The cancer can be seen but it is not larger than 4 cm (about 1 3/5 inches).
- **T1b2**: The cancer can be seen and is larger than 4 cm.

T2: In this stage, the cancer has grown beyond the cervix and uterus, but hasn't spread to the walls of the pelvis or the lower part of the vagina. The cancer may have grown into the upper part of the vagina.

T2a: The cancer has not spread into the tissues next to the cervix (called the *parametria*).

- **T2a1**: The cancer can be seen but it is not larger than 4 cm (about 1 3/5 inches).

[2] http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-staged

- **T2a2**: The cancer can be seen and is larger than 4 cm^2.

T2b: The cancer has spread into the tissues next to the cervix (the parametria)

T3: The cancer has spread to the lower part of the vagina or the walls of the pelvis. The cancer may be blocking the ureters (tubes that carry urine from the kidneys to the bladder).

T3a: The cancer has spread to the lower third of the vagina but not to the walls of the pelvis.

T3b: The cancer has grown into the walls of the pelvis and/or is blocking one or both ureters (this is called *hydronephrosis*).

T4: The cancer has spread to the bladder or rectum or it is growing out of the pelvis

Lymph Node Spread (N)

NX: The nearby lymph nodes cannot be assessed

N0: No spread to nearby lymph nodes

N1: The cancer has spread to nearby lymph nodes

Distant Spread (M)

M0: The cancer has not spread to distant lymph nodes, organs, or tissues

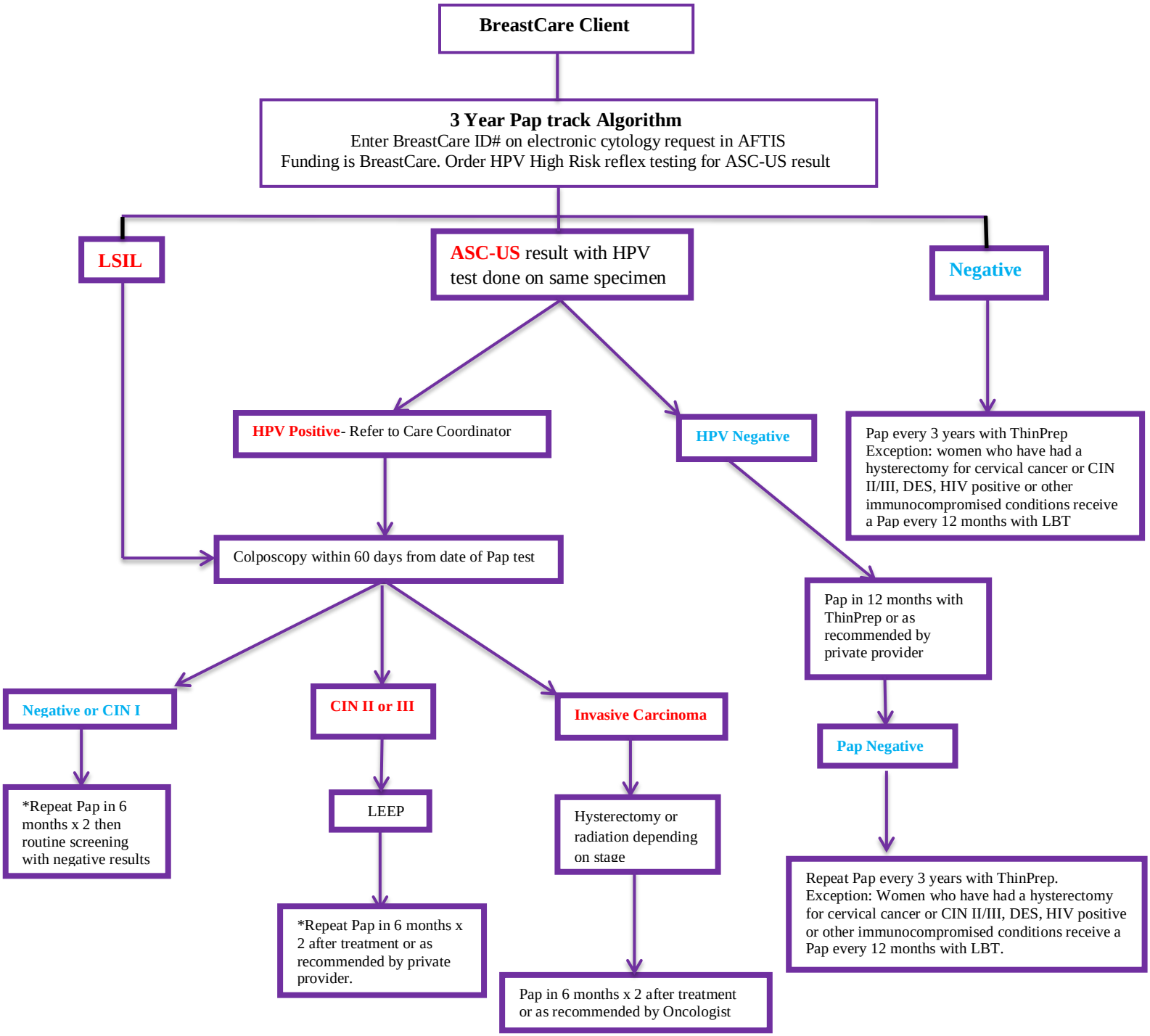
M1: The cancer has spread to distant organs (such as the lungs or liver), to lymph nodes in the chest or neck, and/or to the peritoneum (the tissue coating the inside of the abdomen) [2].

Adequacy of Follow-Up Algorithm for Cervical Cancer Screening

Diagnosis	Recommendations
Negative **for Intraepithelial lesion or malignancy**	Follow-Up according to clinic guidelines
ASC-US **Atypical Squamous Cells of Undetermined Significance**	ThinPrep liquid based Pap: HPV DNA high risk reflex test performed on original Pap test specimen. SurePath Pap: HPV DNA high risk test specimen is obtained using the ThinPrep Pap.
ASC-US **with positive HPV**	Colposcopy
ASC-H **Atypical Squamous Cells cannot exclude HSIL**	Colposcopy
AGC **Atypical Glandular Cells** **EC** **Atypical Endocervical** **NOS** **Not otherwise specified**	Colposcopy with endometrial sampling
AGC **Atypical Glandular Cells: Cannot exclude Endocervical Adenocarcinoma in-situ**	Colposcopy with endometrial sampling
AGC-EM **Atypical Glandular Cells-Endometrial**	Colposcopy and endometrial sampling
LSIL **Low Grade Squamous Intraepithelial Lesion**	Colposcopy
HSIL **High Grade Squamous Intraepithelial Lesion**	Colposcopy with endocervical sampling
CA-in-situ/CA **Carcinoma-in-situ and Squamous Cell Carcinoma**	Colposcopy with endocervical sampling

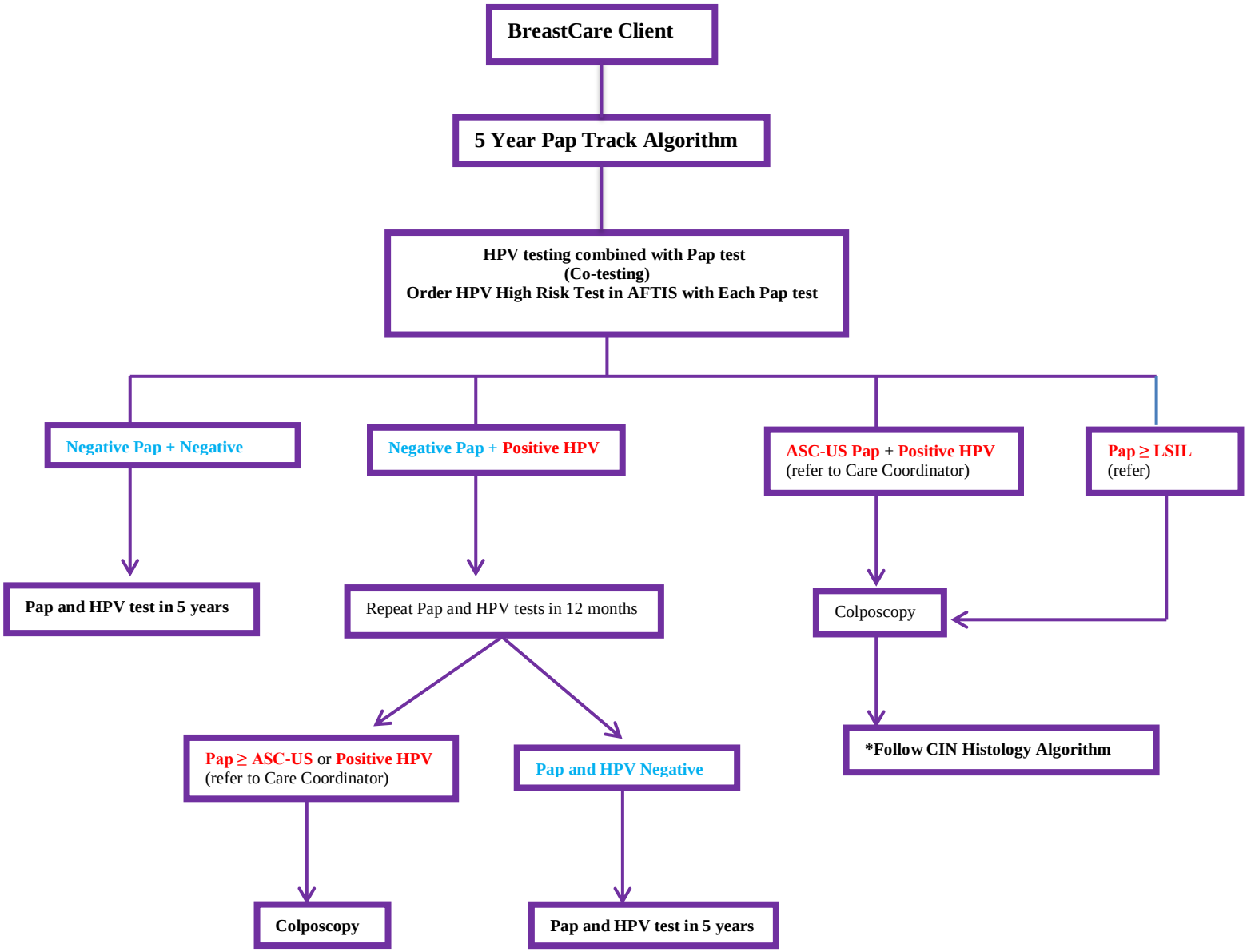
Note: Schedule all patients requiring colposcopy and refer to the Regional Care Coordinator.

A diagnostic work-up must be scheduled when there is a Pap test/HPV result requiring colposcopy/MD consult per ADH policy. The time from an abnormal Pap test or positive HPV test to the final diagnosis should be no more than 60 days. The final diagnosis is the pathology with the most severe result. Results of surgical tissue pathology, which may include conization, LEEP/LLETZ, or hysterectomy, must be entered in the online data system[1].



*See Management for Histological Diagnosis of cervical intraepithelial neoplasia

Note: This algorithm does not apply to women who are receiving both BreastCare and Reproductive Health services through Arkansas Department of Health Local Health Units.



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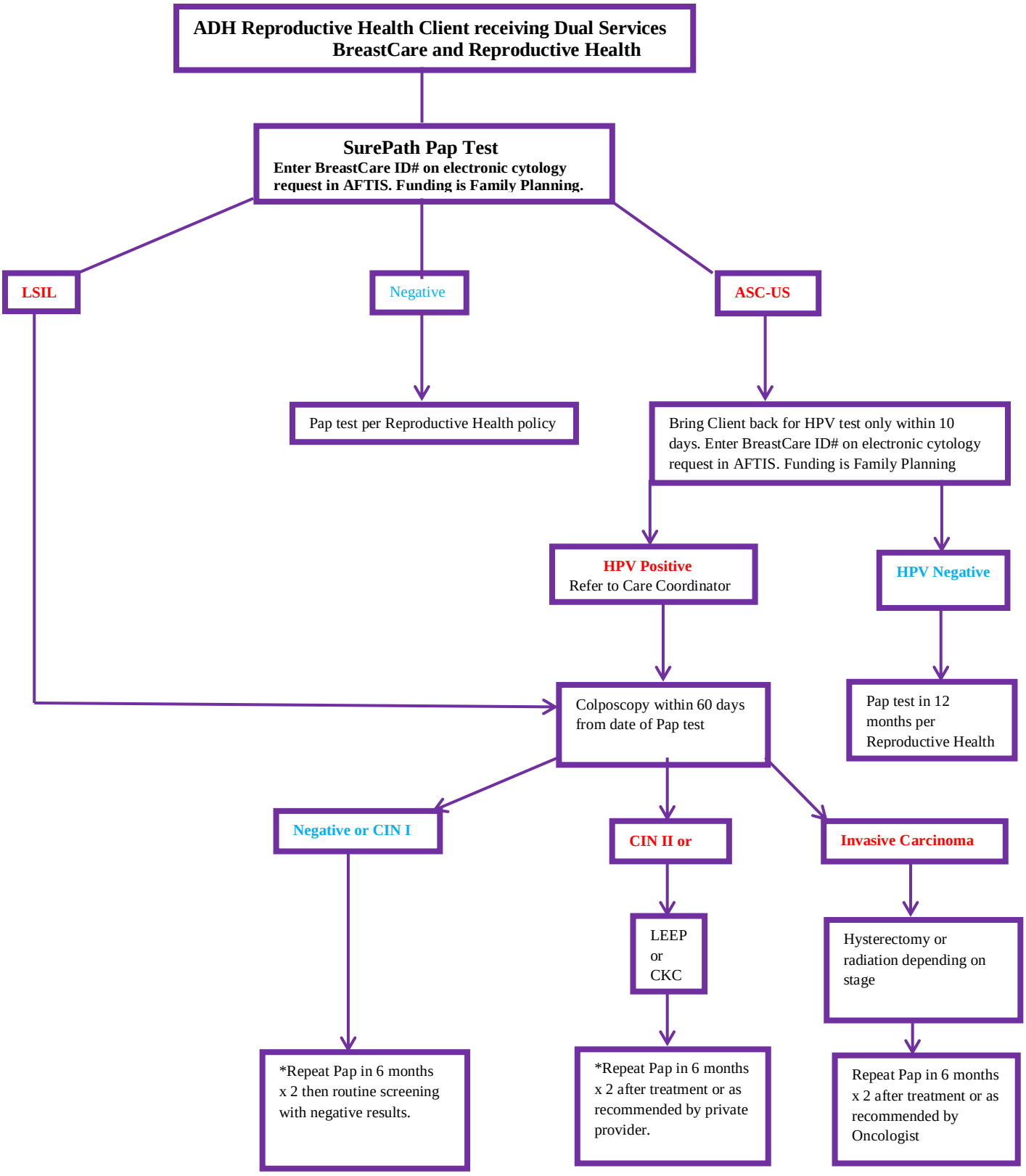
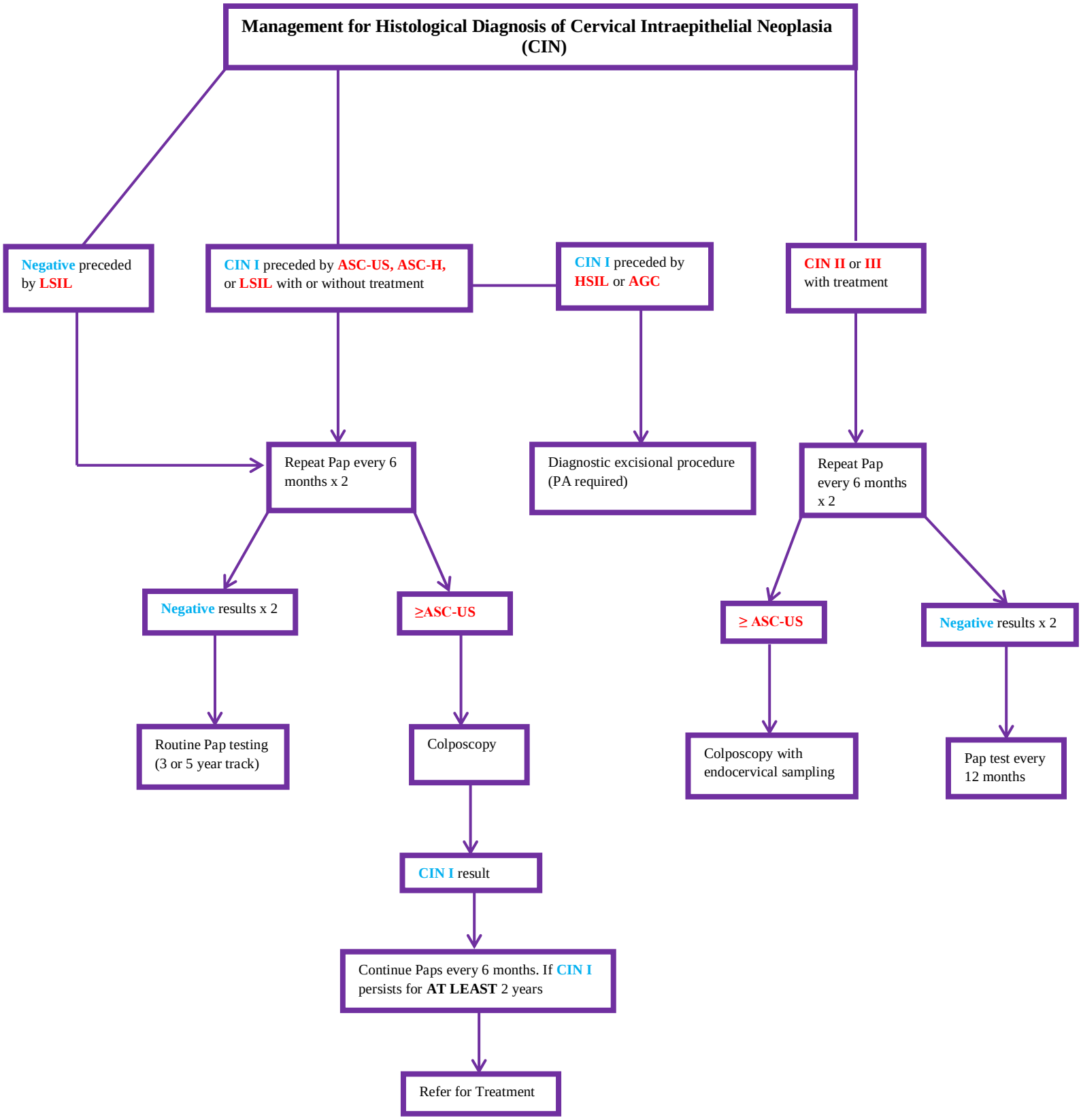


*See Management for Histological Diagnosis of cervical intraepithelial neoplasia

Note: This algorithm applies only to women served at Arkansas Department of Health Local Health Units.



Note: BreastCare/Medicaid does not reimburse for treatment of LSIL

Case Management Referrals

The following abnormal screening results are to be referred to the Care Coordinator for Case Management:

- ASC-US with positive HPV
- LGSIL
- ASC-H
- AEC
- AGC
- AGC-EM
- HGSIL/Carcinoma-in-situ
- Squamous cell carcinoma
- Post-menopausal bleeding
- Repeat Pap ≥ ASC-US or HPV positive
- Women who refuse follow-up for abnormal test results
- Women lost to follow-up after abnormal test results

Referrals should be made within five days of a biopsy result that is positive for cancer.

All clients with a cervical cancer diagnosis or cervical precancerous condition must be referred to the Care Coordinator for possible transition to the BreastCare Medicaid Program.

Arkansas Department of Health (ADH) employees and BreastCare Providers must contact their assigned Care Coordinator by phone to notify him/her of a client, who is eligible for case management services,

The Referral Form (BC-2) and applicable reports, i.e., Pap test/HPV, colposcopy and Privacy Notice Acknowledgement of Receipt (AS-30b) should be faxed to the Care Coordinator.

The client's record should remain open until the Care Coordinator notifies staff that the record may be closed.

Clients diagnosed with cervical cancer or cervical precancers that are not in the BreastCare program should be referred to the Medicaid Case Managers for possible transition to BreastCare Medicaid.

The non-participating provider should fax the pathology report and the last Pap test result to the Medicaid Case Manager at the Central Office[1].

References

1. Arkansas Department of Health, BreastCare Policy and Procedure Manual 3/21/13. http://adhfilehold/fh/filehold/webclientportal/libraryform.aspx

2. American Cancer Society, Inc., 4/11/13 http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-staged